The State Dental Plan

State Dental Plan Contents

Enrolling in the Dental Plan

Enrollment

You can enroll yourself and your dependents in the plan within 31 days of the date you are hired. To do so, complete the required forms, including a Notice of Election form (NOE). Coverage is not automatic. If you begin work on the first day of the month, coverage for you and your dependents will begin the same day. If you begin work on the first working day of the month, coverage may be effective on that day or on the first day of the month after you are hired. If you begin work after the first day of the month, coverage begins on the first day of the month after you begin work.

After you enroll, check your pay stub to make sure the correct amount is being deducted. Your coverage will continue as long as you are a full-time, permanent employee.

Late Entry

If you do not enroll within 31 days of the date you are hired, you must wait until the next open enrollment period. Open enrollment is held every other year. The next one will be in October 2005, and coverage will be effective on January 1, 2006.

Special Eligibility Situation

A special eligibility situation is an event that allows eligible employees, retirees, survivors or COBRA survivors to enroll themselves or their eligible dependents in an insurance plan. Examples include marriage, birth, adoption or placement. Involuntary loss of other coverage is a special eligibility situation only to those who lost coverage. You have 31 days to request a change in your level of coverage.

Changes in Coverage

You can change your coverage only during open enrollment or within 31 days of a special eligibility situation. Open enrollment is held during odd-numbered years. Changes made then are effective on January 1 after the enrollment period.

Marriage

If you marry, you can add your spouse and/or eligible dependent children within 31 days of your marriage by completing an NOE. Coverage becomes effective on the date of your marriage. You cannot cover your spouse as a dependent if he is eligible or becomes eligible for coverage as an employee or retiree of a state-covered employer. Some exceptions may apply. For example, if he is retired from a local subdivision that does not fund retirees' insurance, you may cover him as a dependent. If you do not add your spouse within 31 days of your marriage, you cannot add him until the next open enrollment period or within 31 days of a special eligibility situation.

Divorce

If you divorce, coverage ends the first of the month after the decree is signed. You must complete an NOE to drop your former spouse from your coverage within 31 days of the date of the divorce. However, you may cover your divorced spouse if you are legally required to do so by the terms of the divorce. If you remarry, you can cover your divorced spouse if required to do so by a court, but you cannot cover both your divorced spouse and your new spouse.

You can continue to cover your children if they live with you and you are financially responsible for them, or if you are legally required to cover them. Depen-

dents who lose coverage may be eligible to continue it under COBRA. For details, contact your benefits administrator or EIP within 60 days of the loss of coverage.

Children

A child may be added by completing an NOE within 31 days of the date of his birth, adoption or legal custody. Children must be listed individually on your NOE to be covered by the State Dental Plan. This is required even if you already have family coverage.

Full-time Students

You can cover your dependent children ages 19 through 24 if they meet these requirements:

- They must be attending an accredited high school, vocational/trade school or college/university *full-time*, as defined by the institution they attend.
- Students do not have to attend summer school to keep their coverage. However, dependents who enroll in summer school full-time may become eligible. They will lose eligibility if they do not enroll full-time the next semester/quarter.
- Adult education night classes and correspondence courses do not constitute full-time attendance.

About 90 days before your dependent's 19th birthday, EIP will send a Student Certification letter to your benefits administrator. To continue coverage, this form must be completed and returned to EIP within 31 days of the child's 19th birthday, along with verification that he is a full-time student on letterhead from the institution he is attending. If the child's birthday falls during the summer, return the Student Certification form to EIP with the "Pending Student Certification" block marked. You must submit a letter from the institution verifying that your child is a full-time student by September 30.

If your dependent goes back to school full-time before he turns 25, you may re-enroll him by submitting a Notice of Election (NOE) form and verification of student status on letterhead from the institution, within 31 days of eligibility, the date he is again a full-time student. Unless a child is incapacitated, coverage ends the first of the month after the date he turns 25. It is your responsibility to notify your benefits office when your child is no longer eligible for coverage.

EIP makes random checks of dependents ages 19 through 24. If you cannot prove your child is a full-time student, his coverage will end. You may be required to repay the cost of any benefits he received. Contact your benefits administrator for details if your child is **not** a full-time student, his eligibility for coverage ends the last day of the month in which he turns 19, unless he is covered as an inca pacitated dependent. Your child's eligibility for coverage also will end if he gets married or obtains employment with benefits.

Incapacitated Child

You may continue to cover your child after his 19th birthday if he is incapacitated, incapable of supporting himself, and if you are financially responsible for him. He must meet these requirements:

- The child must have been covered when he became incapacitated.
- The child must be unmarried. He will lose coverage if he does marry.
- The child must be incapacitated because of mental illness, retardation or a

physical handicap and must remain principally financially dependent on the covered employee, retiree, survivor or COBRA subscriber.
- The condition must be established within 31 days of the child's 19th birthday or within 31 days of the date he is no longer a student.
- An Incapacitated Child Certification Form must be completed by the subscriber and the attending physician and then sent to your benefits office.

Gaining Other Coverage

If you or your dependents gain other group coverage, you have 31 days to drop coverage under the Plan by completing an NOE and returning it to your benefits office with proof that you have other coverage. If you fail to do so within 31 days, you must wait until the next open enrollment period. For more details, contact your benefits administrator or EIP.

Loss of Other Coverage

If you or your dependents are insured under another group dental plan and you lose that coverage involuntarily because it was discontinued or the covered employee left his job, you have 31 days from the last day of coverage to enroll in the Plan. To enroll, you must complete an NOE and return it to your benefits office with proof that the insurance was discontinued. If you fail to enroll within31 days, you must wait until the next open enrollment period unless you become eligible to enroll under a special eligibility situation.

Special Provisions of the State Dental Plan

Alternate Forms of Treatment

If you or your dentist selects a more expensive or personalized treatment, benefits will be paid for the less costly procedure consistent with sound professional standards of dental care.

The plan administrator uses guidelines based on usual and customarily provided services and standards of care to determine benefits and/or denials.

Voluntary Precertification

Although it is not required, EIP suggests that you precertify your non-emergency treatment if you have estimated charges of $500 or more. To do this, you and your dentist should fill out a claim form before any work is done. The form should list the services to be performed and how much they will cost. Mail the claim form to BlueCross BlueShield of South Carolina for review.

You and your dentist will be mailed a Predetermination of Benefits form, which will show you what part of the expenses will be covered. This form can be used to claim benefits as the dental work is completed. All you need to do is fill in the date(s) of service, sign the form, have your dentist sign the form and return it to BlueCross BlueShield of South Carolina. Your precertification is valid for one year from the date of the Predetermination of Benefits form. However, the date of service may affect your benefits. For example, if you have reached your maximum benefit before you have the precertified service, you will not receive the amount that was approved on the Predetermination of Benefits form.

Your State Dental Plan Benefits

Your dental benefits are divided into four classes. All benefits are paid on the basis of the *Schedule of Dental Procedures and Allowable Charges* available from your benefits office or EIP. Keep in mind that some services may not be covered under this plan. Please refer to the **Exclusions** section on pages 79-82 of this book for more details.

Class	Services Covered	Yearly Deductible	Percent Covered	Maximum Benefit
I Diagnostic and Preventive	Diagnostic and preventive procedures Cleaning and scaling of teeth Fluoride treatment Space maintainers (child) Emergency pain relief Radiographs (X-rays)	None	100% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
II Basic	Fillings Simple extractions Oral surgery Surgical extractions Preparation of mouth for dentures	$25 per person If you have services in Classes II and III, you still pay only one deductible Limited to three per family per year	80% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
III Prosthetics	Onlays Crowns Bridges Dentures Repair of prosthetic appliances	$25 per person If you have services in Classes II and III, you still pay only one deductible Limited to three per family per year	50% of allowable charges	$1,000 per person each benefit year combined for Classes I, II and III
IV Orthodontia	Limited to covered children under age 19 Correction of malocclusion Consisting of: diagnosis (including models and radiographs) Active treatment (including necessary appliances)	None	50% of allowable charges	$1,000 per lifetime for each covered child

How to File a Claim

The easiest way to file a claim is to assign benefits to your dentist. Assigning benefits means that you authorize your dentist to file claims for you and receive your benefits payment directly. To do this, you must show your dentist's office your dental identification card and ask that they file the claim for you. Be sure to sign the payment authorization block of the claim form. BlueCross BlueShield of South Carolina will then pay your dentist's office directly. You are responsible for the difference between the benefit payment and the actual charge.

If your dentist will not file claims for you, you can file to BlueCross BlueShield of South Carolina. Complete items one through 11 on the claim form and ask your dentist to complete items 12 through 25.

If your dentist will not complete his portion of the form, get an itemized bill showing this information:

1. The name and address of the dentist
2. The patient's name
3. The date of each service
4. The name of each service
5. The charge for each service

Then, complete items one through 11 of the claim form, attach the bill and mail it to:

BlueCross BlueShield of South Carolina
State Dental Claims Department
P.O. Box 100300
Columbia, SC 29202-3300

X-rays and other diagnostic aids may be necessary to determine the benefit for some dental procedures. Your dentist may be asked to provide this documentation for review by BlueCross BlueShield's dental consultant. The plan will not pay a fee for providing this information. A completed claim form should be submitted to BlueCross BlueShield of South Carolina no later than 24 months after charges were incurred or benefits will not be paid.

What If I Need Help?

You can call BlueCross BlueShield of South Carolina at 888-214-6230 or 803-264-7323 in the greater Columbia area. If you cannot call, write BlueCross BlueShield of South Carolina at the above address.

What If My Claim or Treatment is Denied?

If BlueCross BlueShield denies all or part of your claim or proposed treatment, you will be informed promptly. If you have questions about the decision, check the information in this booklet or call BlueCross BlueShield for an explanation.

If you are unsure the decision was fair, you can ask that BlueCross BlueShield of South Carolina re-examine the denial of your claim or proposed treatment. If you are still dissatisfied after BlueCross BlueShield of South Carolina has reviewed its decision, you may request that EIP review the matter by making a written request to EIP within 90 days of notice of BlueCross BlueShield's denial. If the denial is upheld by EIP, you have 30 days to seek review in the circuit court

pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001). The request for review should be made in writing within six months after notice of the decision.

Double Coverage

Coordination of Benefits

A person covered under more than one group dental insurance plan can file a claim for reimbursement from both plans.

If you file more than one claim for reimbursement, your plan administrators will coordinate benefits so you get the maximum amount allowed. That amount will never exceed 100 percent of your covered dental expenses.

If a husband and wife have different group dental insurance plans and both cover their children, the parent whose birthday comes earlier in the year must file a claim under his or her insurance first.

If the State Dental Plan is secondary, you must send the explanation of benefits statement you receive from your primary plan and your claim to BlueCross BlueShield of South Carolina.

There may be some cases in which these rules do not apply. If you are covered by more than one group dental plan and you need more information, please contact your benefits office or EIP.

Exclusions

There are some dental expenses the State Dental Plan does not cover. The dental plan document, which is available in your benefits administrator's office, lists all the exclusions. Some expenses not covered are:

General Services

1. Treatment received from a provider other than a licensed dentist. Cleaning or scaling of teeth by a licensed dental hygienist is covered if performed under the supervision and direction of a dentist
2. Services beyond the scope of the dentist's license
3. Services performed by a dentist who is a member of a covered person's family and for which the covered person was not previously charged and did not pay the dentist
4. Dental services or supplies that are rendered before the date you are eligible for coverage under this plan
5. Charges made directly to a covered person by a dentist for dental supplies (i.e., toothbrush, mechanical toothbrush, mouthwash or dental floss)
6. Non-dental services, such as broken appointments and completion of claim forms
7. Nutritional counseling for the control of dental disease, oral hygiene instruction and training in preventive dental care
8. Services and supplies for which no charge is made or no payment would be required if the person did not have this benefit
9. Services or supplies not recommended and approved by the attending dentist
10. Services or supplies not recognized as acceptable dental practices by the American Dental Association

Services Covered by Another Plan

11. Treatment for which the covered person is entitled under any workers' compensation law
12. Services or supplies that are covered by the armed services of a government
13. Services or supplies that are furnished in a U.S. government facility (or its agent) or by a doctor employed by such a facility

Specific Procedures

14. Space maintainers for lost deciduous teeth if the dependent is age 19 or older
15. Experimental services or supplies
16. Onlays and crowns, when used for preventive purposes or due to erosion, abrasion, or attrition

17. Services and supplies for cosmetic or esthetic purposes, including charges for personalization or characterization of dentures, except for orthodontia treatment as provided for under this plan

18. Myofunctional therapy (i.e., correction of tongue thrusting)

19. Appliances or therapy for the correction of temporomandibular joint syndrome (TMJ)

20. Services to alter vertical dimension and/or for occlusion purposes or due to erosion, abrasion or attrition

21. Splinting or periodontal splinting, including extra abutments for bridges

22. Services for the following tests and laboratory examinations: bacterial cultures for determining pathological agents, caries (tooth or bone destruction)susceptibility tests, diagnostic photographs and histopathologic exams

23. Pulp cap, direct and indirect (excluding final restoration)

24. Provisional intracoronal and extracoronal (crown) splinting

25. Tooth transplantation and surgical repositioning of teeth

26. Occlusal adjustment (complete)

27. Services for temporary repair of fractured teeth

28. Rebase procedures

29. Implant and related services

30. Stress breakers

31. Precision attachments

32. Temporary procedures that are considered part of a more definitive treatment

33. Inlays (cast metal and/or composite, resin, porcelain, ceramic) are not considered a benefit, an alternative amalgam restoration will be allowed

Limited Services

34. More than two of the following procedures during any plan year: oral examination, consultations (must be provided by a specialist) and prophylaxis

35. More than two periodontal prophylaxis (available only to patients who have a history of periodontal surgery). An additional two periodontal prophylaxis may be had in lieu of two prophylaxis procedures provided in number 34 above

36. Bitewing X-rays more than twice during any benefit year or more than one series of full-mouth X-rays or one panoramic film in any 36-month period, unless a special need for these services at more frequent intervals is documented as medically necessary by the dentist

37. More than two topical applications of stannous fluoride or acid fluoride phosphate during any plan year

38. Topical application of sealants per tooth for unrestored, recently erupted molars for patients age 16 and older. For patients age 15 and under, payment is limited to one treatment every three years and applies to permanent unrestored molars only

39. More than one root canal treatment on the same tooth. Additional treatment should be submitted with the appropriate American Dental Association procedure code and documentation

40. More than four quadrants in any 36-month period of the gingival curettage, gingivectomy, osseous (bone) surgery and periodontal scaling and root planing

41. Bone replacement grafts performed on the same site more than once in any 36-month period

42. Additional sites in excess of two bone replacement grafts performed on the same day (payment is limited)

43. Perioscaling for treatment of gingival inflammation if performed more than once per lifetime

44. Tissue conditioning for upper and lower denture units if performed more than twice per unit in any 36-month period

45. Gingivectomy/gingivoplasty in conjunction with or for the purpose of place ment of restorations not considered a separate benefit

46. There is a five-year limitation for cast restorations and prostheses

47. The application of desensitizing medicaments is limited to two times per quadrant per year

48. No more than one composite or amalgam restoration per surface in a 12-month period

49. Replacement of an existing cast prosthesis, including crowns, partial or full removable denture or fixed bridgework, or addition of teeth to an existing partial, removable denture or bridgework, unless evidence is submitted and is satisfactory to the administrator that: (1) the addition of teeth is required for the initial replacement of one or more natural teeth; (2) the existing denture or bridgework was placed at least five years prior to its replacement and that the existing denture or bridgework cannot be made serviceable or (3) the

existing denture is an immediate temporary denture and replacement by a permanent denture is required, and that such replacement is delivered or placed within a period of 12 consecutive months following the date of placement of the immediate temporary denture

Prosthetic and Orthodontic Services

50. Prosthetic devices (including bridges and crowns) and their fitting that were ordered while the person was covered under the plan, but were placed or delivered more than 90 days after termination of coverage

51. Replacement of lost or stolen prosthetic devices, space maintainers or orthodontic appliances or charges for spare or duplicate dentures and appliances

52. Replacement of broken orthodontic appliances

53. Replacement of an existing cast prosthesis unless otherwise specified in the dental plan document

54. Orthodontic treatment for employees and covered children age 19 and over

55. Orthodontic treatment over the lifetime maximum

56. Orthodontic services after the month your dependent becomes ineligible for coverage.

Survivors

Death of an Employee or Retiree

In the event of a death of an active employee, you, as a surviving family member, should contact the deceased's employer to report the death, terminate dental coverage and initiate survivor coverage (if applicable). In the event of a retiree's death, you should contact EIP.

If You Are a Survivor

If you are a covered spouse or child of a deceased employee or retiree, you can continue your State Dental Plan coverage. However, you must pay the full premium. Contact EIP to enroll.

If you are a surviving spouse, you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. If you are no longer eligible for coverage as a survivor, you may be eligible to continue dental coverage under COBRA. Contact EIP for details.

When Your Coverage Ends

Coverage Termination

Your State Dental Plan coverage will end:

- On the last day of the month you leave employment
- On the last day of the month you are no longer eligible for coverage (for example, a change from full-time to part-time status)
- On the day after your death
- On the date the State Dental Plan ends for all employees
- If you do not pay the premium when it is due. (For example, if you are on leave without pay or on COBRA and are paying full cost, you must make a monthly payment.)

Dependent coverage will end:

- On the date your coverage ends
- On the date dependent coverage is no longer offered by the State Dental Plan
- On the last day of the month your dependent is no longer eligible for coverage

If your coverage or your dependent's coverage ends, you may be eligible for continuation of coverage as a retiree or survivor or under COBRA. If you are dropping a dependent from your coverage, you must complete an NOE within 31 days of the date the dependent is no longer eligible for coverage.

If You Are on Leave Without Pay

You can continue your coverage for up to 12 months if you are on leave without pay as long as you pay the premiums. The leave of absence must be approved by your employer or must be a result of injury or sickness. For information about Family Medical Leave, contact your benefits administrator.

COBRA

COBRA is short for the Consolidated Omnibus Budget Reconciliation Act. It requires that continuation of group insurance coverage be offered to you and your dependents if you are no longer eligible for coverage under this plan.

You can continue your dental coverage for a limited time under COBRA if you and your covered dependents lose coverage because:

- Your working hours are reduced from full-time to part-time
- You voluntarily quit work or are laid off or fired (unless the firing is due to gross misconduct)
- You are a separated or divorced spouse
- You are no longer eligible as a dependent child

You must notify your benefits office within 60 days of the date you become divorced or separated, or the date your dependent child becomes ineligible for coverage.

To continue coverage under COBRA, you must complete and return an NOE to EIP within 60 days of the loss of coverage or notification of the right to continue coverage, whichever is later. A premium payment is required to activate coverage. If you are employed by a local subdivision, contact your benefits office to enroll.

If you need more information about COBRA, contact your benefits office or EIP.